



STATE OF IOWA

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DEPARTMENT OF HUMAN SERVICES
CHARLES J. KROGMEIER, DIRECTOR

INFORMATIONAL LETTER NO. 882

DATE: March 10, 2010

TO: Iowa Medicaid Providers Billing on CMS 1500 Claim Forms

ISSUED BY: Iowa Department of Human Services, Iowa Medicaid Enterprise (IME)

RE: Modifier and Payment Policy Updates

EFFECTIVE: February 1, 2010

Since December of 2009, the IME has been alerting providers of our implementation of the National Correct Coding Initiative (NCCI) editing and other Current Procedural Terminology (CPT), American Medical Association (AMA), and national coding guidelines through our website, remittance advice comments and Informational Letter (IL) No. 875.

The IME would like to inform providers that the enhanced prospective claims editing and retrospective review described in IL 875 will not be implemented in this current fiscal year. IME had expected to implement this in February of 2010, but that has been delayed. Further announcements will follow when implementation nears; we expect that will be some time during the next State Fiscal Year (beginning July 1, 2010). Providers are still expected to submit claims according to all applicable national standard principles as required by IL 875.

This letter is simply intended as an informational guide of principles providers should be familiar with when billing IME as we bring the Medicaid payment system more fully in line with national standards. According to NCCI guidelines and under specific circumstances, providers will need to indicate that a procedure or service was distinct, separate or independent from other services performed on the same day. This means that correct use of modifiers will be monitored closely. Modifiers should NOT be used to simply bypass an edit unless the proper criteria for the use of the modifier is met. Providers must maintain documentation in the medical record to justify the use of any NCCI associated modifier. The IME has updated the modifiers recognized by our claims processing system, including their related payment methodologies and other payment policies to be more consistent with CMS and national coding guidelines. Here are specific details:

- 1. Global Surgery Period:** Iowa Medicaid's global surgical days will be consistent with Medicare's 0-10-90 global surgical package. Please note that Iowa Medicaid will follow Medicare's definition of pre and post-op days. Preoperative days begin on the day of surgery for minor procedures and the day before surgery for major procedures. The global surgery period for procedures with a Medicare Physician Fee Schedule (MPFS) Global Surgery Indicator of "YYY" and "MMM" are determined by the carrier. A listing of global surgery days for these codes will be available on the IME website. It will be necessary to append an appropriate modifier to any unrelated E/M services provided during the pre and post operative global surgery periods. Use of a separate diagnosis to specify an unrelated E/M

service does not supersede the need to append a global surgery modifier. Iowa Medicaid will no longer recognize the 57 modifier when appended to E/M services provided on the day of a minor surgery. Iowa Medicaid will follow Medicare guidelines in determining the appropriate use of any global surgery modifiers.

2. **Billing Multiple Units:** Iowa Medicaid's instructions for billing multiple units have not changed. When multiple units of a service are performed, providers will need to continue to bill the service on one line of the claim form indicating the total number of units provided on the specific date of service. Billing the same code, for the same date of service, across multiple claims or lines of a claim, will result in a duplicate billing denial. The AMA and CPT have identified codes that should allow no more than one unit of service per day. It will be necessary to append the appropriate modifier to indicate the rationale for the billing of additional units. Documentation must be kept on file to support the medical necessity of the additional units billed. The Iowa Medicaid allowed units and processes for exceeding maximum units will not change. Please refer to the procedure code's bilateral indicator on the MPFS to determine whether to append the 50 modifier, **or** bill multiple units.
3. **52 Modifier:** This modifier is used to report a partially reduced service or procedure. This modifier should only be used when there is no other CPT code that would better describe the reduced service/procedure. Iowa Medicaid will reimburse codes billed with this modifier at a rate equal to the lesser of the submitted charge or the fee schedule less ten percent.
4. **53 Modifier:** This modifier is used on surgical codes when a procedure is discontinued due to extenuating circumstances or the well-being of the patient is threatened. The provider must submit documentation with the claim indicating why the procedure was discontinued and what percentage of the procedure was completed. Iowa Medicaid will utilize Medicare's preoperative, intraoperative and postoperative payment percentages to determine the applicable amount for reimbursement. Preoperative and postoperative percentages will be paid in full. The intraoperative percentage reimbursement will be reduced as applicable.
5. **54 Modifier:** This modifier is used on surgical codes when the surgeon is billing for the surgical care only. The use of this modifier is only appropriate when postoperative care is turned over to a physician who is NOT a member of the same group as the physician performing the procedure. This modifier should only be appended on surgical codes with a 10 or 90 day global period. Iowa Medicaid's reimbursement for this modifier will be based on MPFS preoperative and intraoperative percentages.
6. **55 Modifier:** This modifier is used on surgical codes when a physician, other than the surgeon or a physician in the same group as the surgeon, provides all or a portion of postoperative care. This modifier should only be appended to codes with a 10 or 90 day global surgery period. The MPFS postoperative percentage will be used to determine the Iowa Medicaid reimbursement for the surgical codes billed with this modifier
7. **62 Modifier:** This modifier is used on surgical codes when co-surgeons are required to perform a procedure. All CPT codes will be updated to limit use of the 62 modifier to codes with a MPFS Co-surgeon Indicator of "1" or "2". The use of this modifier will require the

submission of documentation to support the medical necessity for co-surgeons and will be reimbursed at 62.5% of the fee schedule if approved upon medical review.

8. **66 Modifier:** This modifier is used on surgical codes when a team of surgeons is required to perform a procedure. All CPT codes will be updated to limit use of the 66 modifier to codes with a MPFS Co-surgeon Indicator of “1” or “2”. The use of this modifier will require submission of documentation to support the medical necessity for a team of surgeons and will be reimbursed ‘By Report’ if approved upon medical review.
9. **73 Modifier:** This modifier is used on surgical codes when a procedure performed in an Ambulatory Surgical Center (ASC) was discontinued prior to the administration of anesthesia. This modifier is reserved for use exclusively by the ASC provider type (ASC status with Medicaid is based on CMS recognition as such) and should not be appended on claims submitted by any other provider type. Iowa Medicaid will reimburse surgical codes billed with this modifier at 50% of the ASC indicator payment for the procedure billed.
10. **78 Modifier:** This modifier is used on surgical codes to indicate the return to an operating room, for a related procedure, during the postoperative period of the original surgical procedure. This modifier should only be appended on codes where the original surgery had a 10 or 90 day global surgery period. Payment will be based on the MPFS intraoperative percentage for the code billed. A new postoperative period does not begin for this procedure.
11. **AS & 80 Modifier:** All CPT codes will be updated to limit use of the AS & 80 modifiers to codes with a MPFS Assistant At Surgery Indicator of “2”. For codes with an Assistant At Surgery Indicator of “0” (assistant may be paid with documentation), it will be necessary for providers to submit a provider inquiry to Iowa Medicaid, along with documentation supporting the medical necessity of the assistant. A case by case determination will be rendered based on review of the documentation provided.
12. **TC & PC Modifiers:** Effective March 1, 2010, all CPT codes will be updated to have the technical component (TC) and/or professional component (PC/26) fee schedules and modifiers as indicated on the MPFS. TC and/or PC fee schedules that do not have a MPFS Professional/Technical Component Indicator of “1” or “6” will be end dated.
13. **Diagnostic Imaging Family Payment Reduction:** IME will begin applying a multiple procedure payment reduction on the technical component (TC) of certain diagnostic imaging procedures. The reduction applies to TC only services, as well as the TC portion of the global services for the procedure. When two or more diagnostic procedures have a MPFS Multiple Surgery indicator of “4” and have the same Medicare Fee Schedule Diagnostic Imaging Family Indicator, the following payment reduction methodology will apply. The highest paying procedure will be reimbursed at 100% of the IME Fee Schedule. The TC portion of all subsequent procedures within the same diagnostic family will be reduced by 25%. The reduction will not affect payment for professional component services and does not apply to procedures performed in separate sessions. A session is defined as one encounter where a patient could receive one or more radiologic studies. A separate session includes the patient having a separate encounter on the same date of service for a medically

necessary reason. Documentation must indicate the procedures were performed in separate sessions. If documentation is not attached to the claim, it will be assumed that all procedures were performed during the same session.

14. Multiple Surgery Indicators: The IME will utilize the MPFS Multiple Surgery Indicators to determine the procedure codes subject to the multiple surgery reduction payment methodology. While the IME typically followed these indicators in the past, certain codes sets were excluded from the reduction rules. As of February 1, 2010, these exclusions will no longer apply. All codes with a MPFS Multiple Surgery Indicator of “2”, “3” or “4” will be subject to payment reduction rules. There will be no change to IME’s multiple surgery payment methodology.

Additional information regarding the National Correct Coding Initiative can be found at, <http://www.cms.hhs.gov/NationalCorrectCodInitEd/>. Also, please refer to the WPS Medicare website at, <http://www.wpsmedicare.com/j5macpartb/training/resources/modifiers> or the CMS website at, <http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf> for further information relating to the appropriate use of the above referenced modifiers.

If you have any questions, please contact IME Provider Services at 1-800-338-7909 or locally (in Des Moines) at 256-4609, or e-mail at imeproviderservices@dhs.state.ia.us.